Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ANESTHESIA ALLIANCE OF DALLAS PA
PO BOX 202918
DALLAS TEXAS 75320

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
DALLAS NATIONAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 20

MFDR Tracking Number
M4-11-3381-01

MFDR Date Received
June 6, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has denied payment of Code 01630 AA stating that the 'benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated' and 'anesthesia is included in the surgery procedure.' We sent a reconsideration to the carrier on 4/06/2011, explaining that this code is to be reimbursed separately and payment is **not included** in the surgery procedure. The code billed was for anesthesia services. We received a second denial to our reconsideration, stating the original payment decision is being maintained. We feel this code has been denied in error."

Amount in Dispute: $599.94

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The *Respondent* asserts, and as the EOB reflects, the anesthesia services under the Workers' Compensation State Fee Schedules and the legislated fee arrangement. Finally, the charge exceeded the fee schedule allowance. Thus, the claim was paid properly and in accordance with the Legislative and State Fee Guidelines."

Response Submitted by: Lewis & Backhaus, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 15, 2011	O1630-AA	$599.94	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.1 sets forth general provisions related to medical reimbursement.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

Explanation of benefits dated March 30, 2011

- 45 – Charges exceed your contracted/legislated fee arrangement
- 97 –Payment is included in the allowance for another service/procedure
- U837 – Anesthesia is included in the surgery procedure
- 2551 – This charge was reviewed/reduced according to payer's instructions

Issues

1. Did the requestor the requestor bill for unbundled services?
2. Did the requestor submit documentation to support fair and reasonable reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.203(b) "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."
   - The requestor billed CPT codes 01630, 64415 and 99116 on February 15, 2011.
   - The following CCI edits were identified: Per CCI Guidelines, Procedure Code 64415 has a CCI conflict with Procedure Code 01630.
   - The requestor appended modifier -59 to CPT code 64415 which was reimbursed by the insurance carrier.
   - The division will therefore review CPT code 01630 according to the applicable fee guidelines.
2. Per 28 Texas Administrative Code §134.203 "(f) For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."
   - The CMS fee schedule look up tool does not contain a reimbursement amount for CPT code 01630.
   - The Texas Medicaid fee schedule look up tool does not contain a reimbursement amount for CPT code 01630.
   - CPT code 01630 is therefore subject to 28 Texas Administrative Code §134.1.
3. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 *Texas Register* 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection 134.1(f), which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

5. Former 28 Texas Administrative Code §133.307(c)(2)(G), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - The requestor's position statement / rationale for increased reimbursement from the *Table of Disputed Services* assert that "Insurance carrier denied payment – see attached explanation."
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 14, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.